Iluvien – Yutiq – Retisert (fluocinolone acetonide intravitreal implant)

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

All information to be legible, complete and correct or the request may be denied. FAX DOCUMENTATION INCLUDING PROGRESS NOTES or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

Criteria for Approval:

- ❑ Medication is prescribed by an ophthalmologist
- ❑ Diagnosis of one of the following:
  - Diabetic macular edema (DME)
  - Chronic non-infectious uveitis affecting the posterior segment of the eye

Additional Criteria for Iluvien: (All must be met)

Provider must submit patient's medical record include following criteria:

- ❑ Previously treated with a course of topical ophthalmic corticosteroid and did not have a clinically significant rise in intraocular pressure
  - Medication used: _____Duration of use: _____
- ❑ Not having any of these contraindicated conditions
  - Ocular or periocular infections AND
  - Glaucoma with a cup to disc ratio of greater than 0.8 AND
  - Hypersensitivity to fluocinolone acetonide

Additional Criteria for Yutiq & Retisert: (All must be met)

Provider must submit patient's medical record include following criteria:

- ❑ Treatment of chronic non-infectious uveitis affecting the posterior segment of the eye
- ❑ Previously tried and failed a course of Humira (adalimumab) for at least 6 weeks within last year.
  - Duration of use: _____Details of failure: _____
- ❑ Not having ocular or periocular infections

Additional Criteria for Retisert:

Patient has been diagnosed with chronic uveitis for at least 1 year? ☐Yes ☐No

Note: Illuvien & Yutiq: > 18 years of age
Retisert: >12 years of age

Quantity limit: 1 implant per eye
Authorization period: Iluvien: 36 months Yutiq: 36 months Retisert: 30 months
Reauthorization: permitted if successful treatment of the 1st eye

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date